SUMMARY OF THE ANNUAL REPORT

Office of Medical Director
Farm Security Administration

July 1, 1937 to June 30, 1938

Medical Director

(Dr. R. C. Williams)

The principal problems confronting the Office of the Medical Director are the working out of medical care plans for rural rehabilitation families, the development of plans for medical care for relocation or resettlement families, and the supervision of environmental sanitation of the projects. The planning of an environmental sanitation program for rehabilitation families also requires attention.

It has seemed that the best method of approaching the problem of medical care for rural families on the rehabilitation program has been to obtain an understanding with the State Medical Association. An endeavor then is made to work out in a given county the medical care program suitable to the needs of that county. The local medical care program is based upon the general principles embodied in the agreement with the State Medical Association. Understandings have been arrived at with the following State Medical Associations: Oklahoma, Arkansas, Indiana, Missouri, Ohio, Iowa, Alabama, Tennessee, Georgia, North Carolina, Texas, Wisconsin, Mississippi, Utah and New Mexico. Negotiations are now pending for understandings with the State Medical Associations in Virginia, Louisiana, Kansas, Nebraska, Oregon, and Washington.

These understandings with the State Medical Associations are in reality an agreement from the State Medical Association for the Farm Security Administration to approach a county or local medical society for the purpose of working out the details of a medical care plan for the client families in the county. The most important features of such understandings are (a) that the total amount that the client family expends for medical care for a given period, usually one year, shall be within the ability of the family to pay, (b) that the family shall have a free choice of doctors of medicine, and (c) that the funds may be pooled into a common fund or earmarked individually by families, according to the preference of the local physicians and the local families. Loans are made to the families in order to enable them to participate in these programs.

Medical care programs are now actually in operation in a number of the States where understandings have been agreed upon with the State Medical

Association. Arkansas has the distinction of having the largest number of counties in operation. Fifty-six of the seventy-five counties in Arkansas now have medical care plans in active operation. With the exception of one or two counties, these plans are operating satisfactorily. Several additional counties in Arkansas have indicated their acceptance of the plan. Only six county medical societies in that State have definitely declined to co-operate.

Because of special drought conditions in North and South Dakota the plan for medical care through a state-wide corporation in each State has been continued. The Corporation in each State receives a grant from the Farm Security Administration to provide medical care to members of the Corporation. In North Dakota a grant is made to the Corporation on the basis of $1.00 per family per month. This provides for the services of physicians and surgeons. Hospitalization, emergency dental care and drugs are provided for these families by the State Board of Public Welfare.

In South Dakota a grant of $1.00 per month per family is made to the Corporation. However, there is no State Welfare Board or similar organization in South Dakota, hence the sum of $1.00 per month per family for the families in that State must be used to meet bills for physicians' services, emergency dental care, hospitalization and drugs. Because it has been necessary to markedly reduce bills each month in South Dakota the Professional Inter-Allied Council of that State, composed of representatives from the medical, dental, hospital, nursing and pharmaceutical professions, decided to withdraw from the plan, effective June 30, 1938.

The plan in North Dakota continues in effect.

A special problem exists in California and Arizona of providing medical care for indigent migratory agricultural workers. There are between 20,000 and 25,000 such families in California and approximately 3,400 such families in Arizona. A corporation designated as the Agricultural Workers Health and Medical Association has been set up under the laws of California. This Corporation will receive grants from the Farm Security Administration. A special plan has been worked out with the California State Medical Association whereby any physician who desires to accept this type of work will render services for these families at a reduced fee schedule. Seven District offices for authorizing medical care have been established in those areas of California where there is the heaviest concentration of these families. A similar plan is now being completed whereby this Corporation will provide medical care to these families in Arizona.

A small amount of health education material was issued through this office during the year.

Several conferences were attended in various Regions and the problem of medical care discussed with field personnel

A medical officer (Dr. F. V. Meriwether) assigned from the U. S. Public Health Service, established headquarters at Indianapolis, Indiana on April 15, 1938. An experienced non-medical field worker (Mr. Steele T.

Kennedy) was assigned to this program on March 1, 1938. His headquarters are at Little Rock, Arkansas.

Public Health Engineer
(Mr. D. W. Evans)

During the year the work of the Public Health Engineer has been of a varied nature. Many problems, especially those relating to procuring water supplies and the disposal of wastes, have presented themselves. Much of the time spent on project work has been given to the solution of such problems. Some time was given to the inspection of properties already completed in order to observe the manner in which the facilities for water supply, sewage disposal and garbage disposal were functioning. There have been field visits to seven Regions. Thirty-one projects have been visited. Such assistance as possible has been rendered to the several divisions of this Administration.

Conferences were held with representatives of various state and local Health Departments regarding problems of environmental sanitation.

Last year the officials of Region V, of their own initiative, began such a program in a modest way by making possible the construction of sanitary privies.

Early in the calendar year of 1938 the officials of Region V were approached concerning the enlargement of the sanitation program. It was proposed that in addition to the construction of sanitary privies, water supplies be repaired to afford some protection and that the houses be screened against flies and mosquitoes.

Sixteen counties were selected to carry on this sanitation program. The procedure used in starting such a program in each county followed much the same pattern. The selected county was visited and some time taken to explain the purpose and methods to both county and district supervisors. At each home the well was inspected and the County Supervisor was instructed as to repairing it. Privies were inspected and advice given as to whether they were satisfactory and, if not, where a new one should be located. The house was then observed to see whether it could be screened. Before leaving a given house some time was devoted to explaining the method of securing repairs, how to estimate the cost, the proper material to be used and where aid in supervision could be expected.

No definite standards have been suggested since it is felt that under widely varying conditions inflexible standards might defeat the purpose of the program. Some general suggestions as to equipment are given since actual cost of repair is necessary. A certain type of screen door developed in screening programs carried on by other agencies is suggested since it has been found to be inexpensive and durable. A certain type of pump is recommended for use in the wells.

It is also emphasized that client labor should be used to the utmost extent possible since outside labor could not be employed with the amount of money available.

A follow-up is planned on this work in order to ascertain the results and to secure more accurate information as to the cost.

On the whole, this program has received a very favorable response, both from the County Supervisors and from client families.

Assistant to Medical Director
(Dr. F. D. Mott)

The Assistant to the Medical Director is, in general, responsible for the promotion, organization, development and supervision of the medical care programs in the community projects. Numerous field trips have been made during the year. Regular reports are received from project physicians, nurses, and health associations. Constant guidance and assistance is required in connection with the employment of personnel, the development of suitable facilities, the securing of medical equipment, the preparation of legal documents, and the modification and improvement of existing programs.

Assistance has also been given in the development of medical care programs for rehabilitation clients. Field trips have been made to counties in North Carolina, Virginia, Delaware, Pennsylvania, New Jersey and Maine, in connection with this work.

During the past fiscal year medical care programs have been instituted in the following community projects: Westmoreland Homesteads, Greenbelt, Greendale, Tygart Valley Homesteads, Cumberland Homesteads, Ashwood Plantation, Irwinville Farms, Coffee Farms and Gees Bend Farms. Programs have been organized and will be established in the immediate future in Roanoke Farms and Greenhills.

Existing programs have been supervised and in certain instances modified in the following projects: Arthurdale, Red House Farms, Skyline Farms, Plum Bayou and Lake Dick.

The groundwork has been laid for the future development of medical care programs in Jersey Homesteads, Austin Acres, Duluth Homesteads, Ironwood Homesteads, Christian-Trigg Farms, Penderlea Homesteads, Shenandoah Homesteads, Aberdeen Gardens, Piedmont Homesteads, Bankhead Farms, Palmerdale, Gardendale, Greenwood and Cahaba.

Medical care programs have been organized so far in sixteen projects. In all but three of these there are voluntary health associations. Aside from the salaries paid public health nurses, the medical care programs are subsidized by the Farm Security Administration in but four of the sixteen projects, and in two of these the amount of subsidy for the new fiscal year has been sharply reduced. An effort is being made to eliminate subsidy altogether at the earliest possible date.

In nine projects there are full-time or part-time physicians. In two projects the physicians receive their entire salary from the Farm Security Administration; in five projects the physicians are paid entirely from funds contributed by the families, and in two projects their salaries are derived from both sources. In five projects there are programs based on an open panel of physicians. General practitioner care is available in all the projects. Special arrangements have been worked out for hospital care and specialists' services in six projects. Similar arrangements will be made in other projects when the economic situation justifies increased regular payments by the homesteaders.

C O N C L U S I O N S

Experience in developing medical care programs for rural rehabilitation clients during the past year has served to clarify and sharpen the viewpoint on several phases of this subject. It is well established by experience that physicians as a whole will co-operate in developing these programs. No State Medical Association has definitely refused to work out an understanding with us, although two have postponed action. In the states in which agreements have been worked out only a small number of county medical societies have refused to develop a local plan. Arkansas is the only state in which a large number of counties have plans in actual operation. There are 75 counties in this state. There are now in operation in Arkansas 56 county plans. Only six counties have positively refused to co-operate. In other counties plans are either pending or no definite action has been taken. In various other states only a small percentage of the counties approached declined to co-operate.

Actual experience, therefore, indicates that the physicians are not presenting any insuperable obstacles to the development of this program. The following are the chief difficulties that so far have been encountered:

1 - A lack of uniformity as to policy for those families whose farm plans will not permit an additional or supplementary loan to participate in the medical care plan in a county. A definite, uniform policy should be established with respect to this.

2 - In all Regions where medical care plans are being developed it has been found that in a number of counties an unduly long period intervenes between the time an understanding is reached with the County Medical Society and the time the program is actually put into effect. The interval that usually occurs varies from one to six months. Every effort should be made to consummate the plan and put it into effect promptly after obtaining an agreement from the county medical society.

3 - It is important that a definite policy be established as to whether Farm and Home Management Supervisors or clerical employees in local

offices will be permitted to act as Trustee or Secretary-Treasurer for the local medical care plan. The use of such employees for this purpose is highly desirable -- certainly in the initial stages of the development of these plans. Difficulty has been experienced in obtaining persons having no connection with the Farm Security Administration to act in this important capacity.

4 - At the present time a limitation of $2,500 is imposed on loans that may be approved in the Regional offices. This is a serious handicap to the medical care program and should be removed, as in numerous instances the medical care plans for a given county exceed this amount.

5 - It has been noted in certain Regions and certain states that the Regional, state or local personnel of the Farm Security Administration for various reasons do not take an active interest in the development of the medical care programs. The causes for this vary from want of interest to personal convictions that there is no need for such medical care plans. It is felt that some authoritative statement to all field personnel from the Office of the Administrator should be made on this subject. It should be emphasized that the development of the medical care plans is as definitely a part of the work of all field personnel as any other activity. Undoubtedly medical care is an important factor in the ultimate rehabilitation of these families. This fact cannot be stressed or reiterated too frequently to the field personnel. Contrary to what was expected at the beginning of this program, the chief obstacles encountered are not opposition from physicians or medical associations, but within our own ranks through indifference, lack of co-operation and positive opposition.

6 - Definite progress has been made in the medical care program for the families who are our responsibility. In order to hasten this progress additional field personnel is needed. Two non-medical field workers have been requested. It is felt that the addition of these persons to the field force is essential to the successful conduct and expansion of the medical care program.

7 - The experience gained during the past twelve months has been most valuable. With the progress of the entire rehabilitation program, medical care will prove to be an important factor in the ultimate success of the rehabilitation work.

8 - Medical care programs have been organized in sixteen community projects. In all but three of these, voluntary health associations have been set up and serve as the agency to conduct the programs. In nine of the sixteen projects there are part-time or full-time physicians. In five community projects there are programs based on

an open panel of physicians. General practitioner care is available in all of these sixteen projects. In six of the projects, the health associations have worked out arrangements for hospital care and the services of specialists. The medical care programs are subsidized by the Farm Security Administration in only four of the sixteen projects; namely, Arthurdale, Tygart Valley Homesteads, Red House Farms, and Cumberland Homesteads. It is felt that satisfactory progress is being made in developing medical care programs in the community projects.

9 - Community nurses are actively engaged in twelve of the sixteen community projects where medical programs have been organized. The salaries of these nurses are paid by the Farm Security Administration. These community nurses have been most useful in the medical care programs and in public health work for their respective communities. Community nurses should be maintained until the projects are financially able to assume this responsibility.

10 - During the next few months medical care programs will probably be organized in a number of other projects. It is important that supervision and technical assistance be rendered to all projects until the medical care programs are firmly established.

11 - In the community projects the operation of waste disposal plants and water supply systems require technical advice from time to time. Such necessary assistance will be furnished in a consultant capacity.

12 - The environmental sanitation plan relating to the rehabilitation families should be expanded when it has been sufficiently developed and placed on a sound basis.

13 - The great need for a program of dental care is clearly recognized as applying to the homestead families as well as to the rehabilitation families. Plans are under way to develop some program that will endeavor to meet these dental needs. Specific efforts are now being made to that end in Arkansas and Missouri. If a satisfactory method can be worked out it is hoped to be able to apply the plan to other areas.

ANNUAL REPORT

Office of Medical Director -- Farm Security Administration
For Fiscal Year July 1, 1937 to June 30, 1938

At the beginning of the fiscal year the personnel of the Office of the Medical Director consisted of the Medical Director, one Public Health Engineer, one Assistant to the Medical Director and one clerk-stenographer. During the year the following personnel has been added to the office: One Assistant Medical Director, a medical officer detailed from the U. S. Public Health Service; one non-medical field worker, assigned from the Community and Co-operative Services Section of Rural Rehabilitation Division; and one clerk-stenographer.

In general the work of this office has been continued along the lines that were followed during the preceding year. The principal problems to be met are the working out of plans for medical care for rural rehabilitation families, the development of plans for medical care for relocation or resettlement families and the supervision of the environmental sanitation of the projects; also the development of an environmental sanitation program for rehabilitation families. During the previous fiscal year some attention was given to the supervision of conditions on Land Utilization projects that would be inimical to the public health, with particular reference to the breeding places for mosquitoes that may transmit malaria. With the transfer of the Land Utilization work to the Bureau of Agricultural Economics this office is no longer concerned with that phase of the work.

On the whole there has been excellent co-operation from Regional and State offices, as well as the various Divisions of the Washington Office.

The Medical Director has general supervision of all the work carried on by this office.

Medical Director

(Dr. R. C. Williams)
Assigned from the U. S. Public Health Service

Rural Rehabilitation

It has seemed that the best method of approaching the problem of medical care for the rural families on the rehabilitation program has been to obtain an understanding with the State Medical Association. Then an endeavor is made to work out in a given county a medical care program suitable to

the needs of that county; the local medical care plan to be based upon general principles embodied in the agreement with the State Medical Association. By the close of the fiscal year ending June 30, 1937, understandings had been worked out with the State Medical Associations in Oklahoma, Arkansas, Indiana and Missouri.

During the present fiscal year understandings have been worked out with the State Medical Associations in the following states: Ohio, Iowa, Alabama, Tennessee, Georgia, North Carolina, Texas, Wisconsin, Mississippi, Utah and New Mexico. Negotiations are now pending for understandings with the State Medical Associations in the following states: Virginia, Louisiana, Kansas, Nebraska, Oregon and Washington. These understandings with the State Medical Associations are in effect an agreement from the State Medical Association for representatives of Farm Security Administration to approach the county or local medical societies for the purpose of working out the details of a medical care plan that is mutually acceptable for the client families in a county or district. The understanding with the Georgia State Medical Association, given below, is typical of the plans that have been agreed upon by the various State Medical Associations. Many of them vary somewhat in detail but all of them include the general principles set forth in the Georgia understanding:

"A Program For Medical Care for Farm
Security Administration Clients in
Georgia."

The Economics Committee of the Georgia State Medical Association, as a result of a series of conferences with representatives of the Farm Security Administration, recommends the following program to provide medical care for the clients of Farm Security Administration in Georgia.

Data submitted by representatives of Farm Security Administration reveal that approximately 10,000 families residing in the rural communities of Georgia are clients of the Farm Security Administration. Loans averaging from $100 to $400 per annum are made by the Farm Security Administration to assist such clients in paying for necessities and rehabilitating their farms so that they can eventually become self-sustaining. As soon as these families become self-sustaining or can obtain loans from private sources, they are removed from the Farm Security Administration lists. To be eligible a client must have derived the major portion of his income within the past year from farming. In formulating the rehabilitation budget of clients which serves as a basis for loans, the Farm Security Administration may set up an amount to be used for medical care for the family during the year. The net amount of cash these families have for spending averages from $50 to $150 per annum.

Representatives of the Farm Security Administration requested the co-operation and assistance of the Georgia State Medical Association and its component societies in developing a program to provide medical care for its clients in Georgia, which program would assure clients of the services of a competent physician when required, at such fees as the families are able to pay, and which would insure attending physicians some compensation for their services.

The Georgia State Medical Association will co-operate with and assist the Farm Security Administration in an effort to supply Georgia clients of the Administration with reasonably adequate medical service and recommend to its component societies that they do likewise provided the principles and procedures outlined herein are adhered to by the Farm Security Administration.

Any program to provide medical care for clients of the Farm Security Administration in Georgia shall include the following basic features:

1 - Such program will be made available only to those low income farm families who are clients of the Farm Security Administration.

2 - Negotiations for the formation and administration of a medical care program in each county or district shall be carried on by the Farm Security Administration with the local medical society (county or district) which will act for the medical profession of the county or district in working out a joint agreement on all phases of the medical care program developed in that county or district.

3 - Each client shall have the right to select the physician of his choice among physicians who are willing to take part in the medical care program developed locally.

4 - The local medical society (county or district) will furnish the Rehabilitation Supervisor a list of the physicians who have agreed to participate in the medical care program. The Supervisor in turn will furnish the medical society (county or district) with the names of the Farm Security Administration clients in the area concerned. The Rehabilitation Supervisor will advise clients of the names of physicians who are willing to participate in the program. He shall give each client a memorandum showing that the recipient is a Farm Security Administration client.

5 - Loans will be made by the Farm Security Administration to clients to enable them to participate in the medical care plan. These loans will be based upon the expected cash income of the client, the farm plan and the size of the client family and shall average $25.00 for each client family. In the event that the family is in such condition that services required would make this fee extremely inequitable, the physician will so report to the representative of the Farm Security Administration and to the Economics Committee of the Medical

Association of Georgia who will arrive at an equitable amount. Under such circumstances the Rural Rehabilitation supervisor will attempt to supplement the amount that the client can borrow by a grant to take care of such an unusual situation.

6 - Funds loaned to clients for the medical care program in a given area (county or district) may be placed in a central fund. Payments to a physician for services from such fund shall be made monthly according to a fee schedule.

7 - A fee schedule for services rendered (except major surgery) shall be agreed upon by the local medical society and the Committee on Medical Economics of the State Association.

8 - Any bill submitted for services rendered which appears excessive or irregular shall be referred to the local medical society for adjustment before the bill is authorized to be paid. If satisfactory adjustment cannot be made by the local society, the bill is referred to the Committee on Medical Economics of the State Association for adjudication and this Committee's decision shall be final.

9 - Physicians participating in the program will be expected to furnish Farm Security Administration clients and their families the services usually rendered by a family physician. Services shall consist of home and office visits, including obstetrical care. It will not include major operations and hospitalization, although it is understood that the Farm Security Administration will endeavor in individual cases to secure funds to the amount of $50.00 for each major operation and a proportionate amount for minor operations either through grants or additional loans for emergency surgical cases and hospitalization. In the event the combined loans which are held on deposit for the payment of medical bills should become exhausted before the end of the fiscal year, the physicians agree to render medical service throughout the remainder of the year without compensation.

10 - Controversies regarding any phase of the program shall be referred to the local medical society for adjudication. Questions that cannot be settled locally will be referred to the Economics Committee of the Georgia State Medical Association for review."

Medical care plans based on understandings with State Medical Associations are now in operation in the following states: Alabama, Arkansas, Georgia, Indiana, Iowa, Idaho, Mississippi, Missouri, Ohio, Oklahoma, Tennessee and Texas.

In general, two plans have usually been followed in attempting to develop medical care programs for clients in various sections of the country. First, an understanding is worked out with the State Medical Association. Then, in a given area, a county, for example, the funds loaned for medical care for all of the clients in that county will be pooled into one fund and placed in the hands of a Trustee. A certain amount of this total is then designated for hospitalization and emergency conditions, including surgery. The remainder is then divided into equal parts corresponding with the number of months during which these funds are to be used. Physicians' services are paid for

from the monthly amounts, bills being paid in the full amount if funds are available. If the total bills for a given month exceed the amount available, all bills are proportionately reduced. In case the total bills are less than the amount available, the balance remaining after bills are paid is carried forward to the succeeding month. It has been the policy in such counties that if at the end of a designated period, such as a year, some funds remain, such funds are used to keep paying bills for months in which there was prorating of the bills, or the funds remaining may be returned to the client family.

Another plan has been that in a county or given area the funds set aside for medical care, although placed in the hands of a trustee, are kept separate for each family, the physician agreeing to provide medical care for the sum designated. In the event that the amount of medical care rendered during the year is less than the sum set aside, the remainder is refunded to the family. If the amount for medical care exceeds that set aside by a given family, the physician continues to render service during the remainder of that period without additional compensation. In counties where the individual family accounts are kept separate, it has sometimes been the policy to pool a certain amount for hospitalization and emergencies.

The above, of course, refers to the ordinary rural rehabilitation clients in various parts of the country. It does not apply to those especially distressed areas where a state-wide plan has been initiated, such as in North Dakota, South Dakota and the indigent migratory agricultural workers in California.

The experience with the two plans mentioned above clearly indicates that in dealing with the families of the economic level of our clients, it is most advantageous to the clients that the funds for a given county or area be pooled and that these funds not be kept on an individual basis. Obviously this is a form of voluntary insurance. Because of the low economic level of those families, any other method seems unfair to the physicians concerned, and in many instances would place an insurmountable financial burden upon the families.

In case of catastrophic illness, it is impossible for any family in this income level to meet such conditions without financial ruin or without destroying the hope of ever becoming again financially solvent.

In many areas local physicians are rendering services with little or no compensation to the families whom we are endeavoring to rehabilitate. In most cases these families postpone as long as possible requesting medical care for the reason that they either owe the physician or feel a hesitancy in asking for service for which they know they cannot pay.

As examples of the need for medical care, the following are cited:

Case I

In the State of Mississippi a family that is being assisted by theFarm Security Administration had the following experience:

A child, age 3, became violently ill about 12:30 P.M. The child was brought by the father to the office of the family physician as promptly as possible. On reaching the physician's office it was found that he was out of town and would not be back for several hours. The child was then carried to the office of another physician with the request that the child be examined and the necessary treatment given. The physician inquired as to whose child it was and on being informed that it was the child of (name omitted) he immediately refused to have it brought into his office for examination. The father then carried the child back to his home and endeavored to get other physicians but failed to get in touch with them. The child grew continually worse and died during the night.

This family did not owe the physician who refused treatment any bill, although it is understood that at one time the father did owe 75¢ to this physician and his partner.

This illustrates a case in which a physician refused service to a patient although the family owed him nothing.

Case II

In the State of Iowa, a prominent physician in the county was approached for the purpose of discussing the medical care program for Farm Security Administration clients in that county. This physician asserted that all low-income families in that county were receiving adequate medical care. The physician was then asked if he did the practice for a certain family. He stated that he had been doing their work. He was then asked if he knew that the 18-year old son of this family had suffered an accident to the knee several weeks previously. The physician admitted he did not know this. Upon interrogation the family stated that they did not have a physician see the injured boy for the reason that they did not have funds to pay for the physician's services. The boy who was injured is disabled and can now do very little, if any, farm work. It is possible that his injury may be permanent.

This illustrates the fact that physicians are often not aware of the need for medical care even in the families whom they ordinarily serve.

Case III

A borrower from the Farm Security Administration, living in Indiana, age 32, has a wife and four children. He was renting 35 acres of land and driving the school bus. Last May he applied for a loan and at that time possessed a horse, jack, two milk cows, one sow and some chickens. A loan of $355 was made to him. In December he came to the County Supervisor and complained of a severe pain in his back, to such an extent that he was unable to work. The family physician made the following statement: "On December 31 of last year I examined Mr. (Name omitted). This examination consisted of both physical and X-ray examinations. I find that he has a kidney stone located in the right kidney and I suggest that this stone be removed." The family physician further states that "before this individual can get any relief it will be necessary to remove the stone and local physicians are not equipped for such an operation." Contact was made by the County Supervisor with several

physicians and only one would consider taking the case and that was for a fee of $110 for the operation and examination. The hospital bill would be in addition. The State Relief Administration allows only $50 for such an operation.

This person was brought to Indianapolis and contact was made with a group of physicians in private practice. The statement was made by a representative of these physicians that it would take from $35 to $40 to make the examination, there would be a minimum hospital bill of $91 and they would make no estimate as to the amount of the surgical fee.

This man is now unable to perform any duties. He has had to give up driving the school bus and has been practically bed-ridden since December. The Relief Trustee for the county states that they will pay for the hospital bill in the county, but there are no hospitals in the county in which this operative work can be done. This man has been totally incapacitated for a number of months, his crop is lost and his wife and family are being supported by the township.

This case illustrates the need for hospitalization and special treatment.

Health Education Material

Education leaflets dealing with the following subjects have been prepared and forwarded to the various Regions for distribution:

1 - Care of the Sick
2 - Keeping the Baby Well
3 - The Care of the Teeth
4 - Facts about Cancer
5 - The Need for Medical Care
6 - A simple Plan for Screening the Farm Home
7 - The Sanitary Privy for Farm Homes
8 - Safe Water Supplies for Farm Homes
9 - Prevention and Cure of Pellagra

This material was intended to be adapted by the various Regional offices as seemed desirable and distributed by the State or local offices in accordance with plans determined in the field.

North Dakota

Because of drought conditions and crop failure through several successive years in North Dakota, a corporation was set up in that State, late in 1936, for the purpose of providing medical care to the families receiving assistance from the Farm Security Administration. This Corporation has received grants from the Farm Security Administration for this purpose. For the first several months the grants to the Corporation were on the basis of $2.00 per family per month.

In November, 1937, the medical care plan was modified in North Dakota so that the North Dakota Farmers Mutual Aid Corporation would receive a monthly grant from the Farm Security Administration on the basis of $1.00 per family per month, these funds to be used for the payment only for physicians' (or Surgeons') services. In case the bills for a given month exceed this amount all bills are proportionately reduced. The average payment to physicians under this plan has been about 87% of the bills rendered. The expense of emergency hospitalization, emergency dental care, as well as drugs for the Farm Security Administration families, is met by the North Dakota Board of Public Welfare. The plan has proved practicable and satisfactory.

An example of the expenditures for a given month is given in the following table:

North Dakota Farmers Mutual Aid Corporation

Physicians' April, 1938 bills by amount of charges

Amount of Bill	Number of Bills	Total Charges	Percentage of Bills	Percentage of Charges
Under $2.00	881	$1,235.20	25	4
$2.00 - 2.99	463	1,171.30	13	3
3.00 - 3.99	400	1,359.10	11	4
4.00 - 4.99	303	1,297.30	9	3
5.00 - 9.99	483	3,450.40	14	10
10.00 - 19.99	362	5,023.70	10	14
20.00 - 29.99	352	8,192.00	10	23
30.00 - 39.99	69	2,304.40	2	7
40.00 - 49.99	26	1,161.40	1	3
50.00 - 99.99	170	9,826.30	5	28
100.00 & Over	2	216.40	-	1
	3511	$35,237.50	100	100

South Dakota

Conditions in South Dakota as regards drought and crop failure during the past few years have been, in general, similar to those in North Dakota. A medical care program along the lines of the one originally instituted in North Dakota was put into effect in South Dakota during the spring of 1937. This plan consisted in the making of a monthly grant to the South Dakota Farmers Aid Corporation to meet the medical, hospital, dental and drug bills for emergency care. During November, 1937 this plan was modified in order to reach all clients, standard as well as emergency and grant clients. An understanding was had with the Professional Inter-Allied Council of South Dakota which is composed of representatives of the State Medical Association, State Dental Association, State Hospitalization Association, State Nurses

Association and State Pharmaceutical Association. The plan agreed upon was to the effect that the Farm Security Administration would make a grant on the basis of $1.00 per family per month to provide medical care for its clients.

South Dakota has no state-wide organization that is charged with providing public assistance, such as medical care. It is not possible, therefore, to secure assistance from a State Board of Public Welfare as in North Dakota. This $1.00 per month must, therefore, be used in the payment of hospital, dental, and drug bills as well as for physicians' services. This has markedly reduced the amount that the various professional groups receive in South Dakota for providing medical care for families of the Farm Security Administration. The allotment of all funds available for medical care was on the following basis: Of all funds available physicians would receive at least 52%, hospitals 32%, dentists 12%, druggists 30% and nurses 1%. On an average, the percentage of the bills paid for the various professional groups, as compared with the charges rendered, has been approximately:

Physicians,	52% of bills rendered
Hospitals,	52% of bills rendered
Dentists,	32% of bills rendered
Druggists,	85% of bills rendered
Nurses,	100% of bills rendered.

Because of the limitation of funds and the uncertainty as to the amount of the bills that would be paid, the Professional Inter-Allied Council of South Dakota decided to withdraw participation from this medical care plan effective June 30, 1938. With the suspension of this plan medical care will be provided for emergencies through grants on an individual basis.

It is expected that negotiations will be held with representatives of the North Dakota State Medical Association and the Inter-Allied Council of South Dakota during the fall of 1938, with a view to endeavoring to work out a mutually acceptable medical care plan for South Dakota.

South Dakota Farmers Aid Corporation

Physicians' April, 1938 Bills by Amount of Charges

Amount of Bill	Number of Bills	Total Charges	Percentage of Bills	Percentage of Charges
Under $2.00	477	$ 530.00	17	2
$2.00 - 2.99	297	618.60	17	2
3.00 - 3.99	360	1,100.50	13	4
4.00 - 4.99	194	801.90	7	3
5.00 - 9.99	623	4,379.90	22	15
10.00 - 19.99	382	5,343.50	13	18
20.00 - 29.99	238	5,686.60	8	19
30.00 - 39.99	58	1,931.60	2	7
40.00 - 49.99	26	1,138.50	1	4
50.00 - 99.99	135	7,324.90	5	25
100.00 & over	2	305.30	-	1
	2,792	$29,161.10	100	100

California

In the State of California a special problem exists of providing medical care for approximately 30,000 families of indigent migratory agricultural workers. These families have been in the State less than one year and are not eligible for any aid from the State or local agencies.

The State relief administration of California declines to provide any aid for any person or family unless they have been in the State for more than one year. County authorities decline to provide aid of any sort unless the families have been in the State for three years and in a given county for one year. Data whichare considered to be reliable indicate that at present there are between 20,000 and 25,000 migratory agricultural families who have been in California less than one year and who, for that reason, are not entitled to State or local relief. There is little work for these families. They are experiencing considerable difficulty in securing food and many of them are in urgent need of medical care. It is interesting to note that all of these families are of original American stock. None of them are Filipinos or Japanese, a very small number are Mexicans and there are a few Indians. The majority of these families come from Oklahoma, Arkansas and Texas.

Many of these families were induced to come to California by advertisements placed in local papers by persons who were anxious to secure labor in picking cotton or harvesting fruit during the fall of 1937. These families are willing to work but due to excessive numbers they have depressed the already low wage scale. It should be observed here that the majority of farming in California is industrialized and on a large scale. About 30% of all the farms in the United States above 10,000 acres in size, are in California. There is need for large concentration of labor in various parts of the State in certain seasons of the year. The wage paid these persons depends upon the available supply of labor.

Most of the migratory families travel by means of a rickety automobile, with a tent, coal-oil stove, a scanty supply of clothes, a few cooking utensils and dishes. They tend to group themselves in what are known locally as "Ditch Bank Camps." Some of these camps contain as many as 200 families, although the average is from 10 to 50 families. Tents are pitched in the dirt. Water, in many instances, is taken from polluted sources, such as an irrigation ditch or a running stream. These are the so-called "squatter camps". "Grower camps", that is, camps maintained by persons operating a farm, usually have toilet facilities and water available. These camps are under more or less supervision by county health authorities.

It is estimated that in the State of California there are probably 250,000 migratory families. The group with which we are concerned in this study represents the so-called "submerged tenth", that is, the lowest stratum comprising from 20,000 to 25,000 families.

A corporation designated as the "Agricultural Workers Health and Medical Association" was set up. The Board of Directors of this corporation consists of four officials of the Farm Security Administration and three phy-

sicians, one representing the California State Board of Health, another representing the California Relief Administration and the third representing the California State Medical Association. The headquarters of the corporation above mentioned are located at Fresno. By the end of the fiscal year seven district offices of the corporation had been established at the following places: Tulare, Fresno, Madera, Merced, Stockton, Marysville, and Woodland.

The personnel of the district offices consists of one or more medical social workers and a clerk-stenographer. Indigent migratory agricultural workers, who are in need of medical care and who are not eligible to receive state or local assistance, may apply at these offices for authorization to consult a physician for medical care for any member of the family. The medical social worker determines the eligibility of the person. Care is taken to see that all beneficiaries come within the scope of those persons who are the responsibility of the Farm Security Administration.

In Arizona a situation exists similar to that in California; the principal difference being that in Arizona there are approximately 3,400 indigent migratory agricultural families as compared with 20,000 to 25,000 families in California. These families in Arizona are distributed principally in Maricopa County where are located 90% of these families in the State. A small number of such families - 150 to 200 each - are in Pinal and Yuma Counties. The development of a plan for medical care for these families in Arizona, through the Agricultural Workers Health and Medical Association, is now being undertaken.

Assistant Medical Director

(Dr. F. V. Meriwether)
Assigned from U. S. Public Health Service

Through the co-operation of the Surgeon General of the United States Public Health Service, Surgeon F. V. Meriwether was assigned to assist in the field work of this office, effective April 15. Headquarters for his activities have been established at Indianapolis, Indiana. It is expected that he will devote his time to the states in the several regions in that area. Considerable progress has been made in organizing county medical care programs in Region III since Dr. Meriwether's arrival there.

On several occasions interest has been expressed as to the number of families rejected for rehabilitation who had medical problems. In order to obtain some definite information on this subject, a study was made of 46 cases in Howard County, Missouri, which had been rejected for loans during the past three years. Of the 46 cases rejected, 12 were known to have medical problems. These problems are listed as follows:

Insanity	1
Tuberculosis	2
Defective Vision	1
Heart Disease	1
Crippled hands	1
Low mentality	1
Pyorrhea and defective denture	2
Deformed feet	1
Anemia	1
Hernia	1

Of these cases at least seven can be met through immediate medical care. The other five cases would require time or the placing in public institutions to relieve the families of the immediate expense and care of the individuals who are incapacitated.

Of the remaining 36 cases ten could not be located and probably had moved from the county. Of the remaining 26 cases on which no definite medical history could be obtained, an attempt was made to visit and determine if a medical problem entered into the case. The records of the County show that of these 26 cases investigated the following reasons were given for rejection:

Heavy indebtedness	6
Senility	5
Alcoholism	4
Not a farmer	1
Moved from the county	1
Credit now established	2
Died	1

On the remaining cases no comment was made. On investigation it was found that 12 of the 26 cases were located. Investigation of these cases showed that five had definite health problems as follows:

Prolapse of rectum and severe hemorrhage	1
Lame in right leg	1
Pyorrhea (severe) with arthritis	1
Asthma	1
Chronic nephritis	1

Four cases were classed as "Poor Judgment", "Trifling" and "Lazy" by the County Advisory Board. On investigation it was found that these individuals are undoubtedly of low mental calibre. The three remaining cases had no health problem and it was interesting to note that they had rehabilitated themselves without financial assistance from any source.

These figures show that 12 of the original group had well known health problems. Of the 12 cases among the 26 on which there was no report made, five had definite health problems and four had health problems in the sense that they were of low mentality. A total of 21 out of the 46 cases originally were rejected for health reasons. Contact could not be made with ten of the cases. Therefore,

it would appear that 21 out of the 36 known cases had definite health problems. It would seem a conservative estimate that at least 50% of the cases rejected for rehabilitation have health problems and that rehabilitation might be effected if this were taken into consideration and appropriate steps taken for correction.

In order to obtain information as to the actual medical care rendered to rural rehabilitation families, a survey was made of 87 families that were scattered in 32 counties in Missouri. Of these 87 families, 78 required the services of a physician last year. The amount of the physicians' bills for these 78 families for the year was $2,585.25, the average amount of the physician's bill per family being $34.93. The total amount paid physicians by these families during the year was $1,410.25, the average amount paid the physicians per family was $19.05. The percentage of payment of physicians' bills was approximately 55%.

Of the 78 families requiring medical treatment 13 cases were hospitalized. The total amount of the hospital bills for 9 of these cases was $542.15, the average hospital bill for these cases being approximately $67.76. The total amount of the above hospital bills paid was $263.75, or an average amount per family of $32.82. Thus it appears that approximately 48% of the hospital bills were paid. Among these families last year there were 22 births; 7 births are expected in the same group for this year.

In this survey inquiry was made as to any physical conditions requiring immediate medical attention. The following are the more common conditions listed:

Removal of tonsils
Operation for goitre
Dental care
Rheumatism
Glasses
Hernia
Gall stones
Hemorrhoids
Ulcer of stomach
Heart Disease

The removal of tonsils and dental care were by far the more common immediate medical needs.

Mr. Steele T. Kennedy, Field Worker

Effective March 1, 1938, a field worker experienced in the development of medical care programs was assigned to devote his entire time to this work in the southern states. This field representative has concentrated his efforts in Arkansas, Texas and Oklahoma. He has, however, spent some time in all of the other southern states with the exception of Alabama and Florida. There follows herewith a statistical summary by states of the medical care plans approved by county medical societies:

State	Total No. Plans Approved by County Medical Societies	No. County Plans Established	No. County Plans being Completed
West Texas (Region XII)	13	9	4
New Mexico	1	-	1
Texas (Region VIII)	1	-	-
Oklahoma	11	6	5
Arkansas	61	56	5
Mississippi	11	6	5
Georgia	5	3	2
North Carolina	5	-	5
Tennessee	1	-	1
Virginia	-	-	-
Total (States Contacted 10)	109	80	28

The activities of this field worker have been most helpful in advancing the medical care work in the southern states.

Public Health Engineer
(Mr. D. W. Evans)

During the year 1937-1938 the work of the Public Health Engineer has been of a varied nature. Much of the project planning had been finished and construction was well under way. As is to be expected in this type of work many problems, especially those relating to procuring water supplies and the disposal of wastes, have to be met. Consequently a large portion of the time spent on project work was devoted to the solution of such problems. In all one hundred and thirty five days were spent on field work, while the remainder was devoted to administrative duties. Field work was divided among seven regions. Assistance was rendered to Regional personnel as well as project engineers and inspectors. Some little time was given to the inspection of properties already completed in order to observe the manner in which the facilities for water supply, sewerage, drainage and garbage disposal were functioning. Conferences were held with officials of various State and County Health Departments regarding problems of sanitation. The time spent in the Washington office was devoted to conferences with the various division personnel on plans for health programs at the projects; to office routine on the handling of correspondence; and to the co-ordination of sanitation activities with the U. S. Public Health Service.

Regions and Projects Visited

In Table #1 attached to this report are shown the various projects visited with a brief statement describing the type of service rendered. During the second half of the year the project work was curtailed because of the press of work occasioned by the initiation of an environmental sanitation program for rehabilitation clients.

Sanitation Program for Rehabilitation Families

For some time it has been realized that much could be done toward securing permanent rehabilitation of low income farmers if improvements could be made in the environment in which they lived. This is particularly true when applied to the sanitation of the home in relation to the water supply, the proper disposal of human wastes and the control of insect pests that transmit disease. Officials of Region V of their own accord and in a modest way started such a program in 1937 by making possible, through grants, the construction of sanitary privies. Grants ranging from $10 to $30 were made to certain families and used for the construction of privies. The following table shows the approximate number of sanitary privies built in the four states comprising Region V.

State	Number of Privies built in 1937
Alabama	1900
Florida	1500
Georgia	2000
South Carolina	3500
Total	8900

This was a logical step in the initiation of such a program since in these States because of State and local health work more progress in the prevention of disease is secured for every dollar expended than in some other sections of the country. To a large extent hook work disease is controlled, and aid is rendered in the prevention of typhoid fever, diarrhea, dysentary and certain intestinal parasitic diseases. In most cases this work caused little burden to the County Supervisors after the grant money had been received since the construction of privies was done either by contractors or by Works Progress Administration.

During January, 1938, the officials of Region V were approached concerning the enlargement of a sanitation program. It was proposed that in addition to the construction of sanitary privies that water supplies be repaired to afford some protection and that the houses be screened against flies and mosquitoes. Since this additional work could not be handled by the Works Progress Administration and contract work was costly it was decided to try such a program in only a few counties at first, using client labor and having the County Supervisor superintend the work when other aid, such as from a State or County health department, was not available. In this way the method of operation could be varied until some of the problems could be solved. As soon as some applicable methods are found the work will undoubtedly be carried on in other counties.

Sixteen counties were selected in which to carry on this sanitation program - one in each of the areas covered by a District Supervisor, with two districts being omitted in the four States. Preliminary work was started in South Carolina in April, followed by Georgia, Alabama and Florida in May and June.

The procedure used in starting such a program was simple and followed much the same pattern. The selected county was visited and some time was taken to explain the purposes and methods to both County and District Supervisors. About a day and a half was then used in visiting the clients' homes in company with the Supervisors as they carried on their regular field work. At each home the well was inspected and the Supervisor was advised as to the best method of repairing the well to make it sanitary. Privies were inspected and advice given as to whether they were satisfactory and if not where a new unit should be located. The house was observed to see whether it could be screened. At the end of the visit some time was devoted to explaining the method of securing repairs, how to estimate the cost, the type of material to use and where aid in supervision could be obtained.

No definite standards were suggested since it was felt that under widely varying conditions inflexible standards might defeat the purpose of the program. Some general ideas of equipment were given since a low cost of repair was necessary. A certain type of screen door developed in the screening programs carried on by other agencies was suggested since it was found to be inexpensive and durable. A certain type of pump was recommended for use on the wells. It was emphasized that client labor should be used to the utmost since outside labor could not be employed with the amount of money available. No attempt has been made to force such a program on any supervisor and it is noteworthy that all supervisors with whom contact was made were favorably inclined to give the plan a trial.

Follow-up of this work is planned in order to study the problems involved, and to ascertain what kind of a job is done as well as what will be the cost. At the same time observations will be made upon the amount of additional work which it throws upon the Supervisor. Some follow-up work has already been done in South Carolina. However, it was expected that much of the repair work would be done during the interval between cultivating and harvesting the crops, so that any report made now would be premature. It is anticipated that changes will have to be made in procedure to meet local conditions. Such changes have been suggested in South Carolina. Field trips are planned to other counties in the near future to make such adjustments.

In Table #2 attached to this report is shown a summary of the work which will be attempted in the sixteen counties. The estimated cost is mainly for materials except in the cases where the construction of privies will be done by contractors. This is a preliminary estimate based upon the amount of work thought necessary and within the amount of time that may be given to this work by the Supervisors.

State Health Departments Visited

Since part of the duties of the public health engineer involves the close co-operation between the various State Health Departments and the Farm Security Administration personnel, some time has been devoted during the past year in making visits to Health Departments to secure aid where needed and to make such adjustments as were considered necessary. Table #3 shows a list of such visits and the reasons therefore.

Miscellaneous Activities

Table #4 shows a list of other activities carried on and the type of assistance rendered.

Table No. 1

Regional Offices and Projects Visited

REGION I

Greenbelt - Made inspection of lake for mosquito breeding locations and recommended methods of control.

REGION II

Visited Office at Milwaukee, Wisconsin.

Duluth Homesteads - Made inspection of water supplies completed and of those wells in the process of being dug. Made recommendations for certain corrections and locations of wells. Inspected house drainage facilities and made recommendations.

Thief River Falls Farms - Inspected water supplies and made recommendations for repair of existing wells. Inspected completed privies and recommended change in design.

Central Minnesota Farms - Inspected wells to be repaired and made recommendations for methods to be used.

Central Wisconsin Farms - Inspected wells to be repaired and made recommendations for methods to be used.

Southern Michigan Farms - Inspected wells to be repaired and suggested methods.

Saginaw Valley Farms - Made recommendations of procedure and studies necessary for development of water supplies and waste disposal.

REGION III

Visited Office at Indianapolis, Indiana.

Wabash Farms - Made study on water supply and selected site for well and made recommendations on site of waste disposal units.

Decatur Homesteads - Made study and recommendations of water supply to eliminate trouble from excessive iron in water.

Scioto Farms - Inspected wells which were being drilled at too high a cost and made recommendations for repair to existing wells and assisted regional engineer in writing specifications for equipment.

Granger Homesteads - Made study of contamination of wells and recommended methods of correction and assisted regional engineer in assembling specifications.

Osage Farms - Made inspections of farm layouts and study of well drilling operations with recommendations for reducing cost.

REGION IV

Visited Office at Raleigh, North Carolina.

Penderlea Homesteads - Inspected water supply and sewage disposal units.

Roanoke Farms -Inspected water supply and waste disposal units.

Arthurdale - Inspected water treatment facilities and made recommendations for operation and testing. Inspected sewage disposal units and also dairy barn. Conferred with County Health officials regarding supervision.

Tygart Valley Homesteads - Inspected water treatment plants and made recommendations on operation and testing. Inspected three new sewage treatment plants and recommended procedures.

Red House Farms - Inspected water filtration plant, made check tests and recommended purchase of new equipment to insure safety of water supply.

REGION V

Visited Office at Montgomery, Alabama

Coffee County Farms - Made visit with regional personnel to attend meeting of health committee.

REGION VII

Red River Valley Farms - Inspected well drilling operations and made recommendations for methods to prevent the wells from freezing.

REGION VIII

Visited office at Dallas, Texas.

Wichita Gardens - Inspected water supply, sewage disposal and drainage facilities.

Wichita Valley Farms - Inspected completed units, water supplies, sewage disposal units, screening and drainage

Boomer Farms - Inspected farm layouts and well drilling operations and made recommendations on procedure.

Eastern Oklahoma Farms - Inspected completed units and proposed locations.

Fannin Farms - Inspected farm layouts and advised on water supply problems.

Texas Security Farms - Inspected a number of completed units and advised on the water supply and sewage disposal system.

Sam Houston Farms - Inspected completed farm units and made observations on the methods of drilling wells. Inspected drainage and screening.

Woodlake Community - Inspected water supply.

Sabine Farms - Inspected farm layouts and advised on well sites.

REGION XII

Visited Office at Amarillo, Texas.

Ropesville Community - Inspected water supplies and waste disposal on old units and advised on layout of new units.

Bosque Farms - Made investigation of mosquito breeding because of malaria hazard and made recommendations for control.

New Mexico Farms - Studied water supply and recommended drilling test wells to supplement cisterns.

TABLE No. 2

Environmental Sanitation Program
For
Rehabilitation Families in Region V

State	County	No. of Sanitary Privies	No. of Houses to be Screened	No. of Wells to be Repaired	Estimated Cost
Alabama	Franklin	160	150	180	$ 9,880.00
"	Wilcox	150	250	25	7,875.00
"	Autauga	154	175	50	8,120.00
"	Lee	70	85	85	4,775.00
"	Butler	150	150	100	8,000.00
Florida	Washington	25	228	200	4,730.00
"	Alachua	100	500	150	11,000.00
Georgia	Candler	65	65	65	4,387.00
"	Lamar	35	35	40	2,800.00
"	Lee	50	50	50	3,250.00
"	Greene	40	40	40	4,400.00
"	Cherokee	78	125	75	4,575.00
South Carolina	Greenwood	36	71	75	2,910.00
" "	Fairfield	90	25	10	1,715.00
" "	Darlington	85	141	142	4,265.00
" "	Allendale	93	114	119	5,200.00
TOTAL		1401	2204	1406	$87,882.00

Notes: Estimated cost is mainly materials.
A number of sanitary privies have already been built in these counties.
Some houses are fully screened and some partially screened; some cannot be screened.
Well repairs include some new wells, some with curbing, while others include pumps.

TABLE NO. 3

State Health Departments Visited

Alabama - Secured approval of methods to be used for repairing wells and mosquito proofing houses on the sanitation program for Rehabilitation clients. Enlisted aid for building privies.

Georgia - Secured approval of methods to be used for repairing wells and mosquito proofing houses on the sanitation program for Rehabilitation clients. Enlisted aid for supervision.

Iowa - Secured approval of methods for correcting contamination of wells at Granger Homesteads and secured aid in water examination.

New Mexico - Conferred with officials regarding the responsibility for malaria control at hazards created by irrigation and drainage ditches at Bosque Farms.

Ohio - Secured information on the possibility of securing water at the projects at Scioto Farms and in Hamilton County.

Texas - Secured approval of design of sanitary privy which had been refused for construction at several Texas projects.

Virginia - Secured co-operation for examination and inspections of water supply at Shenandoah Homesteads, and on sewerage system at Aberdeen.

West Virginia - Secured aid in correction of water trouble at Red House Farms and arranged for licensing of operators of water and sewerage plants, supervision of plants and testing. Same arrangements were made for Arthurdale and Tygart Valley projects.

TABLE NO. 4

Miscellaneous Activities

With Construction Division:

1 - Assisted in the preparation of standard well specifications to be used on all farms in Region III.

2 - Advised on the collection of data to complete records of well drilling on all farms developed in Regions II, III and VII.

3 - Reviewed plans for well construction for the Southeast Missouri Project and made recommendations for revisions.

4 - Reviewed plans of cistern and filter for construction at rural units at Cincinnati and recommended revisions.

5 - Reviewed plans for disposal of sewage at Tygart Valley Homesteads, Arthurdale, Cumberland Homesteads and California Migratory Labor Camps.

6 - Interpreted water analyses of both general and specific cases to aid in development of water supplies.

7 - Advised on studies of sewage disposal for Saginaw Valley Farms.

With Inspection Division:

1 - Advised on the interpretation of water analyses and conferred with officials regarding standards.

2 - Advised field inspectors at projects on the proper locations of wells and privies.

With Management Division:

1 - Advised on reports concerning repairs to the water system at Three Rivers Project.

2 - Advised on the operation and repair of water system at Shenandoah Homesteads.

3 - Advised on the repair and replacement of inadequate equipment for the water system at Red House Farms.

4 - Made recommendations based upon the inspection of all projects visited which are under Management Division.

With Land Utilization Division:

1 - Prepared general policy for approval upon the malaria control features for impounded water at projects.

2 - Advised on the use of portable water containers for labor forces at projects.

3 - Advised on program of health activities for one project in Florida

4 - Reviewed and criticised a guide for the development of water supplies for all Land Use projects.

5 - Made recommendations on the design and operating features of trailer camps.

6 - Conferred with officials regarding the design of water and sewerage facilities at a number of projects.

Tenant Purchase Division:

1 - Advised on the sanitation features to be incorporated in the general set-up of Tenant Purchase farms.

Rural Rehabilitation Division:

1 - Conferred with Regional officials in Regions IV and V regarding sanitation programs for families.

Office of Medical Director:

1 - Drafted two articles on health information for use in the field.

2 - Furnished regional officials specifications on well construction.

3 - Outlined sanitation duties of full time physicians at projects.

Assistant to Medical Director

(Dr. F. D. Mott)

The Assistant to the Medical Director is, in general, responsible for the medical care programs in the various community projects. The promotion, organization, development and supervision of these programs is left almost entirely in his hands. Numerous field trips have been made during the year. Contacts have been made with the local medical profession in each area, with hospital officials, and local and state public health agencies. Regular reports are received from project physicians and community nurses and in certain instances from the health associations established in the projects. Constant guidance and assistance is required in connection with the employment of personnel, the development of suitable facilities, the securing of medical equipment, the preparation of necessary legal documents, and the modification and improvement of existing programs.

Considerable time has been devoted to the development of medical care programs for rehabilitation clients. Field trips have been made to counties in North Carolina, Virginia, Delaware, Pennsylvania, New Jersey and Maine, in connection with this work. Most of these visits were of a preliminary nature, with a view to the actual establishment of the programs in the autumn of 1938. Prospects for the initiation of programs are bright in Duplin County and Chatham County, North Carolina; Augusta County, Virginia; Kent County, Delaware; Atlantic County, New Jersey; and Aroostook County, Maine. Acceptance of the program by the local medical profession is somewhat dubious in Crawford County, Pennsylvania, and Cumberland County, New Jersey.

The Assistant to the Medical Director has served as a member of the Section on the Preparation of Educational Material of the Nutrition Committee appointed by the Interdepartmental Committee on Health and Welfare.

During the past fiscal year medical care programs have been instituted in the following community projects: Westmoreland Homesteads, Greenbelt, Greendale, Tygart Valley Homesteads, Cumberland Homesteads, Ashwood Plantation, Irwinville Farms, Coffee Farms and Gees Bend Farms.

Programs have been organized and will be established in the immediate future in Greenhills and Roanoke Farms.

Existing programs have been supervised and in certain instances modified in the following projects: Arthurdale, Red House, Skyline Farms, Plum Bayou and Lake Dick.

The groundwork has been laid for the future development of medical care programs in Jersey Homesteads, Austin Acres, Duluth Homesteads, Ironwood Homesteads, Christian-Trigg Farms, Penderlea Homesteads, Shenandoah

Homesteads, Aberdeen Gardens, Piedmont Homesteads, Bankhead Farms, Palmerdale, Gardendale, Greenwood and Cahaba. Two of these communities are already served by public health nurses, namely, Jersey Homesteads and Penderlea Homesteads.

In the following outline there is given a summary of the medical care programs in the various community projects which have been visited so far by the Assistant to the Medical Director. A number of projects not included in this summary are to be visited in the near future, with a view to studying the need for the development of medical care programs. Where such programs are definitely advisable, assistance in their establishment will be given.

REGION I

Jersey Homesteads, Hightstown, New Jersey (206 dwelling units)

The program proposed over a year ago has never been put into effect because of the delay in moving families into the community. When approximately 175 families are in residence, it is proposed that a voluntary health association be organized and that the association employ a full-time physician. The community has shown keen interest in developing such a program.

The Monmouth Memorial Hospital in Long Branch, New Jersey, has agreed to hospitalize all cases, offering specialists' services and diagnostic tests as well, for $1.00 per month per family. The program has never been formally set up on account of the economic situation and the delay in moving families into the community, but the hospital has permitted a few families to make the regular payments and enjoy the protection. When the medical care program is initiated, centering about a community physician, an effort will be made to induce a large percentage of the families to enter into this hospitalization agreement, as well.

The Monmouth County Organization for Social Service supplies public health nursing service to the community.

Dental equipment surplus to the needs of other agencies is being sent to Jersey Homesteads in order that a dental office may be set up. A dentist from a nearby community will then hold regular hours in the community.

Westmoreland Homesteads, Greensburg, Pennsylvania (255 dwelling units)

The Health Club, an unincorporated association, commenced its activities on August 15, 1937, undertaking a program of general practitioner care. The program was approved by the Westmoreland County Medical Society, and all nearby physicians participate. The monthly dues are $1.50 per family, with an extra charge of 25¢ for the first home call in any one illness, 50¢ for any night call after 9 p.m., and $10 for confinement cases. The physicians agreed to a special fee schedule, somewhat lower than their usual schedule. When the bills cannot be paid in full, avail-

able funds are distributed on a pro rata basis.

When organized, the Health Club had but 24 family members. This number increased slowly to 56, then dropped recently to about 45. Despite the small membership, which included a number of bad risks, every physician's bill has been paid in full, and on June 7, after the payment of physicians' bills for May, there was a surplus of about $150 in the treasury.

Side lights on the Medical Care Program:

(a) The underlying causes of the low membership include the internal dissension in the community at the time the program was established, the feeling on the part of some that the program was sponsored by the management, the uncertain economic situation, failure of the Board of Directors to do sufficient educational work and to provide energetic leadership, and a willingness on the part of many homesteaders to accept medical care without paying for it.

(b) The program is not subsidized.

(c) Abuses on the part of patients have been minimal, and there is no evidence of abuses on the part of the physicians.

(d) The physicians are very well satisfied with the program.

A hospitalization program will be inaugurated when the Health Club has a membership of 100 families. The H. C. Frick Memorial Hospital in Mount Pleasant is not unfavorable to accepting a special agreement.

The Project enjoys a good public health program, conducted by a full-time community nurse. The chief weakness in the program lies in a failure to have sufficient corrective work done. This may be attributed to the failure of the community to support adequately the medical care program.

The Westmoreland County Dental Society has been requested to propose some plan whereby the homesteaders may get dental care at a cost which they can pay.

Greenbelt, Maryland (885 dwelling units)

The Greenbelt Health Association, an unincorporated association, commenced its activities in April, 1938, offering a program of general practitioner care to its members, and entering into agreement with a physician to provide the services. The membership, originally about 75, has increased to 160. The monthly membership dues are $2.00 per family. The following extra charges are in effect: For the first home visit in an illness, 50¢; for the first home visit in an illness if requested after 8:00 p.m., $1.00; a 50¢ charge each week if the illness exceeds one week in duration; for confinement cases, $25.00. There is an enrollment fee of $5.00, used for

the purchase of equipment. There are additional fees for extra dependents and higher dues for adult dependents who fail to pass a safisfactory physical examination.

A four-house unit is being converted into a Health Center. The Health Association has leased one unit and will soon lease a second. A dentist has equipped one unit as a private office; he will engage in private practice. The public health nurse will occupy the fourth unit.

The physician receives $300 per month from the Health Association. He is permitted to practice among non-members, handing over 50% of his fees from this source to the Association, in view of the use of the facilities. It is thought that a second general practitioner will be needed within a few weeks, and possibly another later. The physicians will practice as partners.

Possible future developments include an extension of the services to include the care of specialists and hospitalization, the development of a maternity home, and ultimately the erection of a suburban hospital.

The Town Council has approved $1800 per annum for a public health nurse. An experienced nurse has been selected. She will enter upon her duties on July 15, 1938. The Town Council may also pay a small salary to a Greenbelt physician for part-time public health service to the community.

REGION II

Austin Acres, Austin, Minnesota. (44 units)

There is no special need for a medical care program in this suburban project which includes higher income families. If the community becomes interested in developing some phase of a health program, assistance will be given.

Duluth Homesteads, Duluth, Minnesota. (84 units)

No program has been established in this suburban project which includes higher income families. A Health Committee is doing educational work. A group hospitalization plan has recently been inaugurated in Duluth, and the homesteaders will be urged to join it. The prepayment medical service of the Webber Clinic in Duluth has been brought to their attention for study. Any program will be undertaken only as a result of a demand for it on the part of the residents.

Ironwood Homesteads, Ironwood, Michigan (132 units)

This is a higher income, suburban project, located close to Ironwood. The possibility of developing some phase of a health program was discussed with a committee of the residents interested in co-operative activities. Guidance will be given if the community decides to undertake any sort of program.

Greendale, Wisconsin (649 Units)

Two physicians, a married couple, recently moved into Greendale to engage in the private practice of medicine on a moderate fee basis. They are unusually well qualified physicians, covering between them internal medicine, pediatrics and general surgery. One will serve as the local health officer, having once been Assistant Director of Public Health in Pontiac, Michigan, and the other, a pediatrician, will assist in the school health program.

A dentist will soon be selected to engage in private practice. As in the case of the physicians, he will be selected partly on the basis of having a broad social viewpoint. He will aid in the school health program.

School public health nursing may be arranged through the Milwaukee County Institutions. A sum of $600 per month has been included in the school budget for such a purpose.

Office space is available for two physicians and one dentist on the second floor of the Post Office building. This space will be available for occupancy within the next two months.

REGION III

Greenhills, Ohio (735 units)

Recently a Committee selected by the early residents of Greenhills selected a physician to engage in the private practice of medicine in the community. Before making the selection the Committee interviewed several applicants. The physician's fees will be moderate. He will probably move into the community within the next month.

The wife of the physician selected is also a physician but she has not been engaged in active practice for several years. She has, however, served as the medical examiner for a large private school in Cincinnati and she will probably play an active part in the school health program in Greenhills. The salary of a full-time public health nurse has been included in the school budget. Candidates for the position are now being interviewed.

A dentist has recently been selected by the Committee of the residents and he will move into the community at an early date to engage in the private practice of dentistry. He is interested in assisting in the school health program

Space on the second floor of the Administration and Business Building is now being remodeled to provide offices for the physician and the dentist.

Arthurdale Community, Arthurdale, West Virginia (165 units)

Until recently one physician was employed by the Farm Security Administration on a per diem, w.a.e., the equivalent of $3,500 per annum, to provide office care for all the homesteaders and to engage in communicable disease control and sanitary supervision of the project. About June 1, 1938, a change in program was effected whereby a second physician joined the first as a partner. At present two physicians serve the community, each being on a per diem, w.a.e. basis and each receiving the equivalent of $1,750 per annum. The physicians are permitted to engage in private practice in the surrounding area. They charge members of the Health Association 25¢ in the day and $1.00 at night for the first home visit in any illness and charge a fee of $10 for confinement cases. When serving non-members they charge regular fees customary in that area. The purpose of this difference in fees is to stimulate membership in the Health Association.

The Arthurdale Health Association, an incorporated association, commenced its activities on May 1, 1937. The dues were originally $1.00 per month per family. These dues were doubled on February 1, 1938. The benefits include unlimited care in the Infirmary, limited hospitalization in Morgantown, specialists' services, X-ray and other diagnostic examinations, drugs and supplies. As outlined above, the benefits also include home calls at very low fees by special arrangements with the physicians. Also a low fee for confinement cases.

The Arthurdale Infirmary, a converted house, is provided by the Community, is rent free and enjoys free care-taking, fuel, electricity and telephone. There are three beds and two bassinets. The equipment is adequate for most major surgical work and for deliveries. A nurse-technician is employed by the Farm Security Administration. A relief nurse is also on the payroll and there is also a practical nurse for night duty on a non-appointive basis.

The Community has failed to support the Health Association adequately. The membership, which at one time was upwards of 100 families, has dropped to 60 or 70 paid up members. In spite of the low membership and the large volume of service rendered, the Health Association at the conclusion of its first year of activity had a deficit of but $163.00. The Association would rapidly become financially sound if the membership were increased to approximately 100 families. The difficulty appears to lie in the fact that for a considerable period of time medical services were provided for the homesteaders at no cost to themselves. Under the present arrangement non-members enjoy practically the same protection as members, although they are failing to play their part in making the medical care program available. Steps to cure this situation will probably be taken at an early date. It is felt that the new arrangement, whereby the homesteaders have to choose between two physicians, will prove to be more satisfactory than the former arrangement.

The Project physicians co-operate with the County Health Officer in making available to the school certain phases of the public health program. There is no public health nurse in the community at present but there is a possibility that Preston County may employ a third public health nurse who would devote a considerable portion of her time to Arthurdale.

It is probable that a dental care program will be established in Arthurdale within a few months with the aid of funds from an outside source. No free service will be provided but the homesteaders will be given the opportunity to secure dental care upon a moderate fee basis. It is possible that the dentist may extend his services to the children in Tygart Valley and Red House.

Tygart Valley Homesteads, Elkins, West Virginia (195 units)

The Tygart Valley Health Association, an incorporated association, commenced its activities on Januarly 1, 1938. There are at present approximately 100 family members. The regular monthly dues are $2.25 per family. One dollar goes to the Davis Memorial Hospital or the City Hospital in Elkins to cover hospital care and the services of specialists. Eighty cents has been set aside in a reserve fund to assist in paying the salary of the project physician in the coming fiscal year, when Farm Security Administration subsidy is to be decreased. Forty-five cents is set aside for drugs, supplies and maintenance of the Health Center, a house converted for this purpose.

The following extra fees are imposed upon the members by the Association: For the first home call in an illness, 25¢; for such a call if requested after 8:00 p.m., 50¢; for confinement cases, $10.00. These extra charges serve the double purpose of preventing abuses and increasing the funds in the treasury.

From January 1 to June 30, 1938, a physician was employed by the Farm Security Administration on a per diem of $8.89, the equivalent of $3,200 per annum, to provide office care for all the homesteaders and to engage in communicable disease control and sanitary supervision on the project. Through an agreement between the physician and the Health Association, the physician gives members of the Association the benefit of home calls, and obstetrical care at very low cost. (These extra fees go into the Association treasury, the physician receiving nothing himself for this service). He charges non-members regular prevailing fees.

In the coming fiscal year a different arrangement will be in effect. The project physician (a new physician is succeeding the former one) is to receive a per diem of $5.00 w.a.e., the equivalent of $1,800 per annum. The Health Association is to pay the physician $120 per month plus an additional amount if the membership exceeds 120 families. The dues during the coming year will be divided as follows: To the hospital fund $1.00, to the physician $1.00, and for drugs, supplies and maintenance of the Health Center 25¢. The Health Association has a reserve fund in the treasury of approximately $400 to supplement, when necessary, the funds

currently available for the physician's salary. An effort will be made to increase the membership in order that this reserve fund may be guarded and in order that subsidy may be eliminated after June 30, 1939.

There is a full-time public health nurse in the community. She co-operates with the project physician in promoting a comprehensive public health program.

Red House Farms, Eleanor, West Virginia (150 units)

A physician who practices in a town seven miles from the Project is on a part-time salary of $150.00 per month (per diem of $5.00 w.a.e.) from the Farm Security Administration. He holds regular office hours and makes home calls on the project each afternoon and is available for emergency calls out of regular hours. He charges $15 extra for confinement cases. Four rooms in the Administration Building are used for the offices of the physician and the community nurse. Drugs are sold at cost on a cash basis.

The Red House Farms Hospital Association commenced its activities on April 15, 1937, with monthly dues of $1.00 per family. There are at present approximately 100 family members. The benefits are as follows: $50 toward hospital bill of any individual in a year ($100 per family); $25 toward any specialist's bill of any individual in a year ($50 per family); $100 death benefit ($50 for child under 12). Twenty-two hospital cases and one death benefit were handled during the first year - that is, up to April 15, 1938. In all but three cases the bills were paid in full from the fund and on April 15 there was a surplus of about $250.00 In general, surgeons and other specialists have charged the members just the amount of the benefit; i e., $25.00. Although this fund has taken care of emergency cases in a very satisfactory manner, it has not been possible to include much preventive work or the correction of chronic conditions in the program. The dues may be increased during the coming year in order that these further benefits may be provided.

There is an excellent public health program in the community, conducted by a full-time community nurse employed by the Farm Security Administration.

It is hoped that subsidy may be decreased or eliminated after June 30, 1939. An improving economic picture would make possible an increase in the dues to the point where the homesteaders themselves could pay for the services of the general practitioner now employed by the Farm Security Administration.

Christian-Trigg Farms, Hopkinsville, Kentucky (108 units)

A preliminary study has been made of the medical care needs of the homesteaders but no definite program has as yet been developed.

The alternatives are:

(a) Inducing a physician to practice in or near the project, guaranteeing him a definite income from the homesteaders who would form a health association, and possibly by assisting in the payment of dues by loans.

(b) Arranging with a Hopkinsville physician for part-time services for the homesteaders.

(c) Securing the approval of the Christian County Medical Society for a program based on an open panel of physicians with the payment of bills from a pooled fund.

A decision as to which alternative to accept will be made in the near future, after further study of the problem.

It may be possible to place a public health nurse in the project during the coming fiscal year. There is no County health unit in Christian County.

Cumberland Homesteads, Crossville, Tennessee (251 units)

The Cumberland Homesteads Health Association commenced its activities on February 1, 1938. At the same time the Farm Security Administration employed a physician on a part-time basis on a per diem of $5.00 w.a.e. to provide limited office care for all homesteaders and sanitary supervision of the project. The Health Association has been paying the project physician $150 per month for which he provides members with office care, home visits, obstetrical care at low cost ($10) and the care of simple fractures. The physician is permitted to charge non-members regular fees for these services.

The regular monthly dues of the Health Association are $1.50 per family. The funds remaining after payment of the physician's salary are used to provide drugs and supplies for the members.

The Health Association had originally but 74 family members but this number has increased steadily to approximately 125. There is evidence that the community is heartily in favor of the program and that many more members will join the Association when the economic situation has improved.

A small three-room building adjacent to the physician's home is used as a Health Center.

As soon as the program of general practitioner care is a demonstrated success, it is hoped that an arrangement for hospitalization and services of specialists may be put into effect. There is also great need for a dental care program.

The community enjoys a very good public health program conducted by a full-time community nurse under the supervision of the project physician.

Certain changes in the medical care program are contemplated for the coming fiscal year. The subsidy of $150.00 per month, provided by the Farm Security Administration for the part-time salary of the Project physician is to be decreased to approximately $100 per month. The Health Association is making efforts to expand its membership and it has agreed to pay the physician $150 per month at first and $200 per month as soon as possible. It is hoped that after June 30, 1939 all subsidy may be eliminated with the exception of the salary of the community nurse.

Roanoke Farms, Enfield, North Carolina (285 units)

There are two colonies about fifteen miles apart, one for white people, the other for Negroes. There are at present 137 Negro families in residence and 70 white families. Every family has accepted a loan of $30 for medical care. Recently the Roanoke Farms Health Association, an unincorporated association, was organized and its program will soon be put into effect. A full-time physician is to be employed by the Association. He will receive approximately $3,000 per annum plus $300 for travel expense.

The Association will have white members only so far as voting privileges are concerned, but participation in the benefits of the Association will be extended to the Negro colony.

In addition to securing general practitioner care through the employment of a physician, the Health Association will have adequate funds to provide hospitalization, services of specialists and drugs for the homesteaders in the two colonies. There is every expectation of developing a comprehensive medical care program for the homesteaders which will give them a high degree of protection.

A health room is being provided in the Community Building and a physician's office in the Administration Building midway between the two colonies. Equipment is to be secured at an early date.

A public health nurse has been selected to serve the project on a full-time basis. She will enter upon her duties about August 1, 1938.

Penderlea Homesteads, Burgaw, North Carolina (193 units)

No medical care program has yet been developed for Penderlea Homesteads, although preliminary studies have revealed a definite need for such a program. The office of the Medical Director is ready to assist in the development of the program at any time, upon invitation of the Project Manager. The physicians now serving the community on a private practice basis have expressed their willingness to participate in a program based on the payment of fees from a pooled fund.

Early in the present calendar year a full-time public health nurse was employed by the Farm Security Administration to serve the community. A physician practicing in Burgaw was given a per diem to assist the nurse in developing a public health program. There is no County health unit in Penderlea County.

Shenandoah Homesteads, Virginia (171 units in six small colonies)

No medical care program has yet been developed but steps have been taken to initiate a program in certain of the colonies in the autumn of 1938. It is probable that such a program will be combined with those developed for the rehabilitation clients in the same counties.

It is expected that the salary of a public health nurse will be included in the project budget for the coming fiscal year.

Aberdeen Gardens, Newport News, Virginia (158 units)

A preliminary study of the medical care situation has been made and plans have been laid for the establishment of a program, including general practitioner care by a part-time physician and a fund for hospital care and the services of specialists. The agency to handle the program will probably be a voluntary health association. Officials of a Negro hospital in Newport News have shown considerable interest in the possibility of working out an arrangement whereby the homesteaders would be entitled to hospitalization and services of specialists for approximately $1.00 per month per family.

Assistance in developing a public health program will probably be available from existing agencies.

REGION V

Ashwood Plantation, Sumter, South Carolina (164 units)

The Ashwood Health Association commenced its activities on March 1, 1938. Every family (about 140 at present) joined the Association. Each family accepted a loan of $18.00 for general practitioner care. The funds are pooled, 5% is set aside for administrative expenses, and one-twelfth of the remainder is available for payment of physicians' bills each month. Every nearby active physician is participating in the program. The physicians agreed to a special fee schedule lower than their usual schedule. When bills cannot be paid in full the available funds are distributed on a pro rata basis. The March bills were cut about 22%, the April bills about 36% and the May bills about 22%. Unpaid balances are to be paid when possible from future surpluses. The services include office and home care without limitation as to the amount, obstetrical care and the treatment of simple fractures. Bedside and office medication is included. The physicians are reported to be very well satisfied with

the operation of the program. It is hoped that when the economic situation is more favorable it will be possible to include hospitalization and specialists' services. Loans of $18.00 are all that the homesteaders can assume at the present time.

A house has been converted to serve as a Health Center. Later a small Health Center may be erected. Physicians are permitted to hold regular office hours in the Center if they so desire.

An excellent public health program is conducted by a full-time community nurse, in co-operation with the County Health Department.

Although the school children have received some free dental care given by a dentist paid by Lee County, nevertheless the most acute need in the community at this time is for an adequate dental care program.

Piedmont Homesteads, Monticello, Georgia (50 units)

It is probable that an open panel plan similar to that recently inaugurated in Ashwood Plantation will be established in the near future. The physicians have expressed their willingness to participate in such a program.

It is expected that a county or district health unit will be set up in this area soon. This would make public health services available to the homesteaders.

A dentist in Monticello has agreed to give complete dental care to the children for $2.50 per child per year. The program has not yet been organized.

Irwinville Farms, Irwinville, Georgia (115 units)

The Irwinville Farms Health Association commenced its activities on January 1, 1938. The annual dues are $30 per family. The families paid the first quarter's dues in cash, and are being assisted with loans to pay the amount due for the next two quarters. There are at present 76 family members out of 85 families now in residence. An agreement was reached with Dr. Herman L. Dismuke, of Ocilla, the logical physician to serve the project, whereby he visits the project certain afternoons each week for office and home care, and is available during definite hours on other afternoons on which his services are required. He also furnishes hospitalization, surgical care, X-rays, obstetrical care and all ordinary drugs. If he must visit the project out of hours, there is a charge of $1.00 during the day and $2.00 after 7:00 p.m. (Ocilla is 11 miles from the project, and the usual charge for a home call is $7.00). There is also an extra charge of $5.00 for confinement cases. These extra fees go to the physician.

A building is being erected which will include health rooms as well as the administrative offices.

The community enjoys a comprehensive public health program, conducted by a full-time public health nurse assisted by the project physician.

Skyline Farms, Scottsboro, Alabama (123 units)

A medical care program was promoted and organized by the Project Manager. In April, 1937, the Skyline Farms Co-operative Medical Association commenced its activities, employing a physician at a salary of about $200.00. per month to provide general practitioner care and ordinary medicines. Originally the family dues were $1.50 per month, but in the autumn of 1937, on account of economic difficulties, it became necessary to institute a sliding scale of dues, varying with income, ranging from 75¢ for those in the lowest bracket (monthly income of about $21) to $2.50 for those earning upwards of $100 per month. Considerable difficulty has been experienced in the collection of dues. The first physician, who proved unsatisfactory, left Skyline Farms in the spring of 1938, and efforts are now being made to secure a competent physician to succeed him.

A small, four-room building has been used as a Health Center. It is possible that a new building may be erected for this purpose. Ultimately a very small hospital or infirmary may be developed, for maternity and acute medical cases, for the project is somewhat isolated.

A much needed public health program has been developed, conducted by a full-time public health nurse with the assistance of the project physician and the County Health Department.

It is hoped that some arrangement may be worked out for hospitalization and the services of specialists in the not distant future, but it is impossible to do much along these lines until the economic picture is brighter.

Bankhead Farms, Jasper, Alabama (100 units)

No particular problem is presented by this suburban project. The family incomes range from $100 to $125 per month. The project is five miles from Jasper, and the families have their own family physicians in Jasper. Walker County has a county health unit. A state-wide group hospitalization plan is available.

Palmerdale, near Birmingham, Alabama (104 units)

A suburban project, 20 miles from Birmingham. The family incomes average about $120 per month. There is keen interest in the possibility of inducing a physician to settle in the community. The families are willing to guarantee him $24 per family per year, for general practitioner care. There are two physicians in Mt. Pinson, 3-1/2 miles away, but there are often long delays in securing the services of these men and the families, accustomed to city conditions, feel keenly the lack of quickly available medical service.

The Jefferson County Health Department looks after public health needs. The state-wide group hospitalization plan is available.

Gardendale, near Birmingham, Alabama (68 units)

A suburban project, 15 miles from Birmingham, with family incomes averaging about $120 per month. No particular medical care problem. Two physicians practice within four miles. Group hospitalization is available. The Jefferson County Health Department is responsible for public health matters.

Cahaba, near Birmingham, Alabama (288 units)

A suburban project 14 miles from Birmingham. The family incomes will average about $1,600 per annum. A physician will be permitted to settle in the community to engage in private practice. A physician's office will be available in the trading center. A dentist may also be permitted to settle in the community with an office in the trading center.

The Jefferson County Health Department will supervise the public health program. Group hospitalization is available.

Greenwood, Bessemer, Alabama (83 units)

A suburban project 20 miles from Birmingham and five miles from Bessemer. The family incomes average about $120 per month. Over half of the families are entitled to medical care because of the employment of the family heads by the Tennessee, Coal, Iron and Railroad Company. These families lost the privilege of receiving home care when they moved away from Bessemer, and their efforts to secure this care without further cost to themselves have so far been unavailing.

The Jefferson County Health Department will conduct the public health program. Group hospitalization is available for those families which do not already have such protection.

Coffee Farms, Enterprise, Alabama (216 units)

The Coffee County Health Association commenced its activities on January 1, 1938. Its membership includes not only the project families but the rehabilitation clients as well. There is at present a membership of slightly over 311. Family membership dues are $30 per year. Loans have been made to the families for this purpose. $20 goes into a fund for general practitioner care. The Coffee County Medical Society agreed to a special fee schedule about 25 per cent lower than their usual schedule. Funds are distributed each month on a pro rata basis. The bills for January, February and March were cut by an average of about 20%, but the physicians are reported to be well satisfied with the operation of the program.

The remaining $10 of the annual dues goes into a fund for hospital care and the services of specialists. During the first three months a considerable unused surplus was accumulated in this fund. Hospitalization is provided by the Gibson Hospital in Enterprise.

Two public health nurses have been added to the county health unit by the Farm Security Administration. Their services are not confined to clients of the Farm Security Administration but are available throughout the county.

Gees Bend Farms, Camden, Alabama (100 units)

A program has been organized whereby two local physicians render general practitioner care to this Negro project, holding regular clinics in the community and being available for emergency calls at other times. These physicians are reimbursed from a pooled fund created by pooling the loans accepted by the homesteaders for this purpose. It was considered advisable not to organize a health association at this time.

A highly useful public health program has been developed within recent months, conducted by a full-time Negro public health Nurse, with the assistance of the County Health Department.

REGION VI

Plum Bayou, England, Arkansas (101 units)

Commencing in April, 1937, the Plum Bayou Medical and Health Association, with practically every family enrolled, conducted a program whereby a physician from England, 16 miles away, provided general practitioner care to the homesteaders. However, when an agreement was reached with the Arkansas State Medical Association relative to the rehabilitation program, it was felt that the projects should be included in the provision of the agreement calling for freedom of choice of physician. The program has, therefore, been reorganized recently, along the lines of the county rehabilitation medical care programs in effect in Arkansas.

Lake Dick Homesteads, Jefferson, Arkansas (80 units)

Previous to the agreement with the Arkansas State Medical Association, a plan was in effect similar to that in Plum Bayou whereby one physician served the project on a contract basis. However, the program has recently been modified to provide free choice of physician. The agency handling the medical care program is a voluntary health association.

S U M M A R Y

Medical care programs have been organized in 16 community projects. In all but three of these voluntary health associations have been set up to serve as the agencies to conduct the programs. Only three of these associations are incorporated. The others are simple, unincorporated associations, organized along co-operative lines.

Aside from the salaries paid public health nurses by the Farm Security Administration, the medical care programs are subsidized by the Farm Security Administration in but four of the sixteen projects; namely, Arthurdale, Tygart Valley Homesteads, Red House and Cumberland Homesteads. The amount of subsidy for the new fiscal year has been sharply reduced in Tygart Valley Homesteads and Cumberland Homesteads. An effort is being made to eliminate subsidy altogether at the earliest possible date.

In nine of the sixteen projects there are full-time or part-time physicians. In two projects these physicians receive their entire salaries from the Farm Security Administration; namely, in Arthurdale and in Red House Farms. In five projects the physicians are paid entirely from funds contributed by the families. This is true in Greenbelt, Roanoke Farms, Irwinville Farms, Skyline Farms and Gees Bend Farms. In two projects the physicians receive part of their salaries from the Farm Security Administration and part from the health associations, namely in Tygart Valley Homesteads and Cumberland Homesteads.

In five community projects there are programs based on an open panel of physicians; i.e., with free choice of physician. These are Westmoreland Homesteads, Ashwood Plantation, Coffee Farms, Plum Bayou and Lake Dick. Physicians in Greenhills and Greendale engage in the private practice of medicine -- the residents are free to use their services or not as they see fit. In Greenbelt there is, of course, no compulsion forcing the families to join the Health Association and use the services of the Association physician, nor do they have to use his services rendered on a private practice basis, if they care to look elsewhere.

General practitioner care is available in all sixteen of these projects. In six of them the health associations have worked out arrangements for hospital care and the services of specialists for their members, namely, in Arthurdale, Tygart Valley Homesteads, Red House Farms, Roanoke Farms, Irwinville Farms, and Coffee Farms. Similar arrangements will be made in several other projects when the economic situation justifies an increase in membership dues.

Public health nurses are either already actively engaged or will be in the immediate future in twelve of these sixteen projects.

During the next few months medical care programs will probably be organized in the following projects: Jersey Homesteads, Christian-Trigg Farms,

Shenandoah Homesteads, Aberdeen Gardens and Piedmont Homesteads. Certain phases of a health program may be adopted in certain of the suburban projects near Duluth, Ironwood and Birmingham. Projects in Regions X and XI will be visited in the immediate future, and doubtless programs will be established in certain of these.

C O M M E N T

Although most of the medical care programs in the projects have been organized so recently that a reliable analysis of their operation is impossible, nevertheless certain pertinent observations may be made in the light of the experience gained so far.

The agency conducting the program is in each instance the voluntary health association, organized along co-operative lines. These associations represent one answer to the problem of organizing medical service for a logical group of people. They constitute an example of consumer or social action to achieve a socially desirable goal - action which need not wait on governmental or professional initiative. They are voluntary, local, democratic, and strictly on a non-profit basis. They offer training value in democratic processes, and the regular meetings give an excellent opportunity for health education work.

The voluntary health association, however, has all the weaknesses of co-operatives and of democracy itself. There is a tendency for the members to become apathetic, to leave everything up to a handful of those willing to work, to neglect attending meetings. The elected boards of directors usually include natural community leaders, but there is often a failure to elect intelligently those most interested in the program and those who can devote time to it. The boards have in certain instances failed to display initiative and to assume responsibility. They have failed to interpret their own by-laws strictly, allowing damaging laxness to creep into the organization.

It is only fair to point out that in testing the principle of voluntary health insurance in the projects, rather unfavorable soil has been selected. If satisfactory results are obtained within a reasonable period of time, it is good evidence of the intrinsic worth of this method of organizing medical care for any natural group of the population. And, to end on a brighter note, it can be said with truth that in most of the associations, the boards of directors are taking hold with increasing vigor and strengthening their organizations.

Many of the health associations are confronted with membership and collection problems. Where loans have been made to the homesteaders to cover a substantial part or all of their membership dues for the year, as in Ashwood Plantation or Irwinville Farms, for example, the associations include in their membership practically all the families eligible. In those projects where the homesteaders are individually responsible for the payment of monthly dues in cash, membership in the associations varies from about

20% of the families, as in Westmoreland Homesteads, to about 60%, as in Tygart Valley Homesteads. The failure to secure wider backing for the programs is basically due to the fact that insufficient background educational work has been done, a measure apparently fundamental to the success of any co-operative endeavor. Another major obstacle, allied to the first, is the willingness of many families to chance illness, and, when it comes, to accept medical care without any intention of paying adequately for it. Bound up with the latter, and, indeed, a real obstacle to the success of our programs, is the traditional custom of the medical profession to give care regardless of the expectation of payment for the services rendered. Among other reasons for the low membership in many of these health associations may be mentioned the uncertain economic situation in many of the projects, the actual inability to meet the payments in many instances, the lack of sympathetic support for the programs on the part of certain of the project officials, the failure of the boards of directors to do enough promotional and educational work, and the failure to set up a simple mechanism for collections.

Past or continuing paternalism in a project constitutes a serious handicap to any co-operative endeavor. Partial subsidy of the medical care program by the Farm Security Administration need not necessarily come under the heading of paternalism, although it might be so designated in Arthurdale and Red House Farms. In Arthurdale there is a tendency for many families to sit back and enjoy the protection of the medical care program made possible by the concerted efforts of the Health Association and the Farm Security Administration. The policy to date has been for the two part-time project physicians, who are under appointment from the Farm Security Administration, to render certain services to the homesteaders, namely, office care, regardless of membership in the Association. There is, therefore, a tendency for families to make no contribution to the program, even though by so doing they would be entitled to home care, drugs, hospitalization and the services of specialists. In Tygart Valley Homesteads and Cumberland Homesteads the situation is somewhat similar, but is much less serious, particularly in Cumberland Homesteads where the homesteaders seem unwilling to avail themselves of available care unless they are paying their share.

It is felt that there is ample precedent in the Farm Security Administration program for "helping those who help themselves", and it is thought that the medical care policy should be modified so that any financial assistance may be given to those groups of homesteaders who are willing to do their full share, rather than to all homesteaders indiscriminately.

Certain proponents of so-called "co-operative medicine" claim that small, voluntary health associations should secure medical services by employing or contracting with full-time physicians. It is felt that this is not necessarily true. There is no good reason why members of a health association cannot get service from a panel of physicians, as is being done in projects such as Westmoreland Homesteads, Ashwood Plantation and Coffee Farms.

In certain of the projects it has been found desirable to use full-time or part-time physicians. Such a step is almost essential when the community is isolated, or when nearby physicians either cannot or will not furnish care at reasonable cost. Aside from such reasons, however, there are certain advantages to centering the program about one or two physicians. Such physicians can be selected, thus ensuring competent service. Experience shows that the members get more care from the full-time physician, looking at it from the quantitative point of view. Centering the program about one physician or a small group of physicians makes possible a coordinated program of preventive and curative medicine - the physicians use the equipment gathered in a health center on the project; they can dispense drugs, with a resulting saving to the members; they can keep continuous records on the patients, of definite value to the patient and of research value; and their presence in a sense dramatizes the program, a result difficult to attain when care is given by a large panel of physicians.

The full-time physician enjoys certain advantages. He can enter upon his duties and receive an adequate salary without the need of purchasing equipment or paying high overhead charges. He can be busy at once, without having to wait to build up a practice. He can give his patients thorough care, not being forced to think always of the expense to the patient.

There are certain disadvantages to the one-physician plan. One theoretical disadvantage is not materializing except in one or two instances, and that is the opposition of nearby physicians to the plan. Happily the physicians practicing near the projects have in almost every instance been very co-operative, assisting the project physicians in any way when called upon to do so. One difficulty lies in securing competent physicians to fill the positions, for well-trained men interested in such work are hard to find. When such a man is secured, there is a tendency for him to take up the work on a temporary basis only. A real difficulty is found in the restriction of the patients' choice to one physician. Regardless of how competent and personally attractive such a physician may be, there are always a certain number of people who do not care to have him look after their medical needs. Moreover, a certain amount of shifting from one physician to another has its advantages, for the regular physician may become careless about some chronic complaint which has become boresome. Certain of these difficulties may be overcome by expanding the plan into one calling for two physicians working together as partners, or for a group of physicians. There is already a partnership in Arthurdale. There will be one soon in Greenbelt, and it is hoped that this may expand into a medical group.

It is fair to say that in general the full-time or part-time physicians in the projects have not been bothered by abuses on the part of patients. Arthurdale is the exception that proves the rule. Abuses may be prevented by educational work and by setting up safeguards such as extra fees for home calls. They can be and are being cured by the same means.

In the light of our experience to date it is felt that physicians do good work when on salary, but that there should be ways in which the physicians can supplement their incomes. One way to accomplish this is to give the physician a basic salary, which is increased when the number of health association members exceeds a certain minimum. Another way is to permit the physician to charge an extra fee for confinement cases. He may also be permitted to engage in some outside practice, when this can be done without detriment to the best interests of the members. In such a case, the physician is required to pay a percentage of his receipts from such outside sources to the association in view of the use of its facilities.

Those programs which are based on an open panel of physicians, as in Ashwood Plantation and Coffee Farms, are working very satisfactorily. The physicians are receiving pay for services previously given with only the hope of payment, and they are in general very well satisfied with the actual operation of the programs. There is no evidence of abuses on the part of physicians, and virtually no evidence of abuses by patients. There is as yet insufficient experience to go by in judging the adequacy of the care given. There is some evidence that the volume of care given is considerably less than in the case of plans based on full-time physicians. A disadvantage of this type of program is that the care given is necessarily of the same quality previously available from the physicians concerned. There is difficulty in solving the problem of furnishing medicines at low cost, for in most places the physicians are unwilling to dispense the necessary drugs. There is still the transportation difficulty, as well, for most of the physicians participating in these programs have so few patients each that they are unwilling to hold regular office hours on the projects. However, these programs are making care available to those who previously often neglected themselves. Experimentation in this form of medical service is vitally important, for there will never be any comprehensive plans for large numbers of our citizens which are not based on the use of existing facilities and on open panels including most of the doctors of medicine in the areas concerned.

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